



## Review Article

# Medical errors and malpractice in general health care system

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## ABSTRACT

The present review article describes the Medical errors encountered in general health care system and the numbers of patients affected from the medical errors are at a very high count. The purpose of the paper is to understand the reasons of the problem and to devise methods to reduce the problem. Legal cases are discussed in each category of the medical errors to support the fact. A good medical reporting system is encouraged to decrease the phobia for reporting and to make the research stronger.

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## 1. Introduction

The term "error" suggests an unintentional act or omission. Whereas, the term "medical error" suggests an unintentional act that is related to the practice of medicine that may or may not result in harm or death of the patient. Medical errors also includes mistakes done at the end of patients, which could have been prevented by proper education by the physician.<sup>1</sup> Medical errors range from small mistakes to those mistakes which costs life of a patient. It is also important to note what is not included in medical errors; it is not purposeful or reckless actions that are intended to directly or indirectly harm the patient, errors only include those acts which results in harm to patient when a physician is trying to treat the patient with good intentions.<sup>2</sup> A medical error represents a very serious public health problem and posts threats on patient safety during and after hospital stay. Drug errors are one of the major source of medical errors, it can be in form of wrong administration or prescription of drugs.<sup>3</sup>

## 2. Facts

### 2.1. Background

Medical errors are one of the major cause of death in the United States, more than 1000 people die due to medical malpractice every year and hundreds of thousands of people suffer from preventable injuries due to medical errors.<sup>4</sup> A recent report by the Institute of Medicine estimated that between 44,000 and 98,000 patients die each year in the U.S. from medical errors.<sup>1</sup> This report only includes the number of errors that are reported in hospital premises and does not include all the errors that occur in clinics and rural areas. Another area of differentiation is between adverse effects and errors, adverse effects can occur even after full consciousness during the treatment, as everybody has different physiology, and some react to the same medication in different ways under different circumstances.

Errors can arise from two sources: unintentional actions during the performance of routine tasks and mistakes in judgment or inadequate plans of action. The role of humans in this error-generating process is based on active failures and latent failure. Latent failures, those entwined with the design and structure of complex systems, are considered to

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be the most dangerous types of failure leading to human error. Latent failures can also be defined as accidents waiting to happen and they are the most dangerous failures because they are the preventable failures but can result in hazardous effects if not considered.<sup>2</sup>

## 2.2. Types of medical errors

### 2.2.1. Errors at the level of individuals

These can occur at any stage of the treatment from both providers and receiver. There are some unwaivable duties for a physician which they have to be fulfilled. They cannot exercise less than ordinary care in case of any patient.

*Schwartz v. Johnson* will be good example for this type. In this case a Maryland appellate court refused a doctor's attempt to raise assumption of risk as a defense, telling that allowing this would mean that the physician is consented to allow to exercise less than ordinary care. It concluded that a patient's consent for treatment cannot be used to decrease or practice low quality of care.<sup>5</sup>

### 2.2.2. System errors

A system may be doctor's office, an operating room, a hospital or a large network of hospitals. Culture of a system describes the attitude towards the errors. *Wickline vs State of California* case is an perfect example for this type of medical error, in which Wickline went through amputation of the leg due to error made by the system, the error was not a individual error but it resulted from failure of effective communication of the system. Wickline was compensated with 500,000 \$ for the loss.<sup>6</sup>

## 2.3. Influences

Physicians deal with living human bodies and they cannot afford any mistake on human body. During medical education, medical professionals are taught that any mistake regarding patient done by them are Individual failures. The medical system persists in propagating the myth that the system runs without any mistakes or errors and doctor alone will be responsible for any mistake made.<sup>1</sup> Due to all expectations and the myths, physicians always fear from disclosure of medical errors especially in those cases in which the error did not cause any harm to the patient. The fear of litigation is also a big factor for nondisclosure of the events.<sup>4</sup> A physician also holds a duty towards the patient to disclose the medical errors.

## 3. Steps Need to be Taken

### 3.1. Encouraging error reporting

Medical error reduction could decrease the unpredictability of the tort system by raising the overall quality of care. Number of patients injured will be less, decrease in the pool of potential plaintiffs. The change can only be achieved

by studying the errors which can only be achieved if more errors will be reported frequently comprehensively. A good error detecting process should identify errors by individual providers practicing substandard care, identify deficiencies which increase the risk of error by providers within a system, establish methods to reduce errors in both contexts, and provide legal safeguards and market incentives for voluntary error reporting made.<sup>1</sup>

The reporting should be done in two types, first one should be serious events and the other one should be near misses or less serious events. For the serious events, mandatory reporting should be done with full disclosure to public. On the other side in cases of near misses and less serious medical errors, confidentiality and protection from public disclosure should be provided to the reporters so that reporting should be encouraged for future events.<sup>7</sup> The deficiency of standardized nomenclature and the emergence or various different and overlapping errors interferes with data collaboration, analysis and collaborative actions to decrease the problem.<sup>8</sup>

### 3.2. Increasing cost for mistakes

Another way to improve the health care is to increase the cost for the errors made during the treatment. The cost should be high enough that organizations and professionals should give attention to the improve the resources and quality of the care. This kind of pressure is absent in current system because most of the cases of malpractice do not come to court. A strict action is required by regulatory bodies, group purchasers consumers are required to bring out this change.<sup>7</sup>

### 3.3. Improving doctor patient relationship

Recent studies have suggested the excellent patient doctor relationship and good communication reduces the risk of medical litigation especially in physicians working in primary health care. When a doctor tries to understand the psychology of the patient, cracks jokes with them they develop a relation which results in decrease chances of medical errors.<sup>9,10</sup>

## 4. Conclusion

The whole paper describes the impact of medical errors on patients. Adoption of new rules is required to decrease the prevalence of medical errors, a small error can result in hazardous events for both patient and physician, so an adequate system to properly investigate the cases and evaluate the flaws and new implication should be developed. The most important step is developing adequate reporting system, providing a comfort zone to physicians so that they can report the errors to avoid further complications.

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## 6. Conflict of Interest

None.

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